FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044560

Facility Name: EVERGREEN HEALTH CARE CENTER

Address: 10124 S. KEDZIE AVE. (Number) EVERGREEN PARK (City) 60805 (Zip Code)

County: COOK

Telephone Number: (708) 636-9200 **Fax #** (708) 636-7375

IDPA ID Number: 364313705001

Date of Initial License for Current Owners: 11/30/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) Marvin Fox, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	242	Skilled (SNF)	242	88,330	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	242	TOTALS	242	88,330	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,448	15,996	29,769	68,213	8
9	SNF/PED					9
10	ICF	5,409	1,963		7,372	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,857	17,959	29,769	75,585	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.57%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/30/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/30/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 242 and days of care provided 24,970

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	375,468	44,260	7,553	427,281		427,281	1,511	428,792			1
2	Food Purchase		358,879		358,879		358,879	(2,127)	356,752			2
3	Housekeeping		21,174	283,484	304,658		304,658		304,658			3
4	Laundry		2,260	187,640	189,900		189,900		189,900			4
5	Heat and Other Utilities			202,219	202,219		202,219	3,375	205,594			5
6	Maintenance	118,873		190,649	309,522		309,522	(15,411)	294,111			6
7	Other (specify):*							407	407			7
8	TOTAL General Services	494,341	426,573	871,545	1,792,459		1,792,459	(12,245)	1,780,214			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	5,503,755	429,269	88,660	6,021,684		6,021,684	36,231	6,057,915			10
10a	Therapy	156,314	7,691	16,757	180,762		180,762	(2,058)	178,704			10a
11	Activities	123,814	21,836	1,656	147,306		147,306		147,306			11
12	Social Services	129,698		875	130,573		130,573		130,573			12
13	Nurse Aide Training											13
14	Program Transportation	3,536		2,614	6,150		6,150		6,150			14
15	Other (specify):*							5,892	5,892			15
16	TOTAL Health Care and Programs	5,917,117	458,796	152,562	6,528,475		6,528,475	40,065	6,568,540			16
	C. General Administration											
17	Administrative	147,731		1,133,174	1,280,905		1,280,905	205,452	1,486,357			17
18	Directors Fees											18
19	Professional Services			145,675	145,675		145,675	(1,125,334)	(979,659)			19
20	Dues, Fees, Subscriptions & Promotions			124,519	124,519		124,519	(61,781)	62,738			20
21	Clerical & General Office Expenses	394,899	91,679	441,252	927,830		927,830	(156,064)	771,766			21
22	Employee Benefits & Payroll Taxes			1,120,643	1,120,643		1,120,643		1,120,643			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,806	6,806		6,806	2,530	9,336			24
25	Other Admin. Staff Transportation			3,189	3,189		3,189	(716)	2,473			25
26	Insurance-Prop.Liab.Malpractice			305,209	305,209		305,209	4,133	309,342			26
27	Other (specify):*							53,046	53,046			27
28	TOTAL General Administration	542,630	91,679	3,280,467	3,914,776		3,914,776	(1,078,734)	2,836,042			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,954,088	977,048	4,304,574	12,235,710		12,235,710	(1,050,914)	11,184,796			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER #0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,839	13,839		13,839	492,373	506,212			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,234	33,234		33,234	603,393	636,627			32
33	Real Estate Taxes			480,000	480,000		480,000		480,000			33
34	Rent-Facility & Grounds			894,336	894,336		894,336	(865,398)	28,938			34
35	Rent-Equipment & Vehicles			30,514	30,514		30,514	1,586	32,100			35
36	Other (specify):*											36
37	TOTAL Ownership			1,451,923	1,451,923		1,451,923	231,954	1,683,877			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,447,719	2,623,517	4,071,236		4,071,236	(34,228)	4,037,008			39
40	Barber and Beauty Shops	20,797			20,797		20,797	(20,797)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,495	132,495		132,495		132,495			42
43	Other (specify):*	76,028		668	76,696		76,696	(77,146)	(450)			43
44	TOTAL Special Cost Centers	96,825	1,447,719	2,756,680	4,301,224		4,301,224	(132,171)	4,169,053			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,050,913	2,424,767	8,513,177	17,988,857		17,988,857	(951,131)	17,037,726			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(226,753)	30		9
10	Interest and Other Investment Income	(1,994)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(850)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(6,119)	20		19
20	Contributions	(10,724)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(380,151)	21		24
25	Fund Raising, Advertising and Promotional	(51,034)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(304,526)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (982,151)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	31,020		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 31,020		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (951,131)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
EVERGREEN HEALTH CARE CENTER

ID# 0044560
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (6,193)	20	1
2	Vending Income	(1,277)	2	2
3	Barber & Beauty Income	(20,797)	40	3
4	Capitalized R&M	(16,504)	6	4
5	Non-Allowable Auto Expense	(772)	25	5
6	Marketing Salaries	(76,028)	43	6
7	Bank Charges	(135)	21	7
8	Marketing Consultant	(668)	43	8
9	Prepayment Penalty	(92,501)	21	9
10	Amortization Allocation Evergreen HC Realty	(74,675)	31	10
11	Office Expense Allocation Evergreen HC Realty	(82)	21	11
12	Accounting Allocation Evergreen HC Realty	(1,604)	19	12
13	Collections	(1,575)	19	13
14	Non-Allowable Legal	(11,608)	19	14
15	License & Fees - Building Co.	(50)	20	15
16	Travel Expense - Building Co.	(57)	25	16
17				17
18				18
19				19
20				20
21				21
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91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(304,526)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				1,670		(159)						1,511	1
2	Food Purchase	(2,127)											(2,127)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					3,375							3,375	5
6	Maintenance	(16,504)				1,093							(15,411)	6
7	Other (specify):*						407						407	7
8	**TOTAL General Services**	(18,631)			1,670	4,468	248						(12,245)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(5,325)	42,339	(783)						36,231	10
10a	Therapy			252			(2,310)						(2,058)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					5,892							5,892	15
16	**TOTAL Health Care and Programs**			252	(5,325)	48,231	(3,093)						40,065	16
	C. General Administration													
17	Administrative					205,452							205,452	17
18	Directors Fees													18
19	Professional Services	(14,787)	1,604			21,023	(1,133,174)						(1,125,334)	19
20	Fees, Subscriptions & Promotions	(74,120)	50			12,289							(61,781)	20
21	Clerical & General Office Expenses	(472,869)	92,583			224,222							(156,064)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar					2,530							2,530	24
25	Other Admin. Staff Transportation	(829)	57			56							(716)	25
26	Insurance-Prop.Liab.Malpractice					4,133							4,133	26
27	Other (specify):*					53,046							53,046	27
28	**TOTAL General Administration**	(562,605)	94,294			522,751	(1,133,174)						(1,078,734)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(581,236)	94,294	252	(3,655)	575,450	(1,136,019)						(1,050,914)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(226,753)	707,667			11,459							492,373	30
31	Amortization of Pre-Op. & Org.	(74,675)	74,675											31
32	Interest	(1,994)	602,311			3,076							603,393	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(894,336)			28,938							(865,398)	34
35	Rent-Equipment & Vehicles						1,586						1,586	35
36	Other (specify):*													36
37	TOTAL Ownership	(303,422)	490,317			43,473	1,586						231,954	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			37,990	(72,218)								(34,228)	39
40	Barber and Beauty Shops	(20,797)											(20,797)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(76,696)					(450)						(77,146)	43
44	TOTAL Special Cost Centers	(97,493)		37,990	(72,218)		(450)						(132,171)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(982,151)	584,611	38,242	(75,873)	618,923	(1,134,883)						(951,131)	45

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Evergreen Healthcare Realty	100	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 894,336	Evergreen Healthcare Realty, LLC		$	$ (894,336)	1
2	V	32	Interest Income	11,466	Evergreen Healthcare Realty, LLC			(11,466)	2
3	V	32	Interest Expense		Evergreen Healthcare Realty, LLC		613,777	613,777	3
4	V	31	Amortization Expense		Evergreen Healthcare Realty, LLC		74,675	74,675	4
5	V	30	Depreciation Expense		Evergreen Healthcare Realty, LLC		707,667	707,667	5
6	V	19	Accounting Fees		Evergreen Healthcare Realty, LLC		1,604	1,604	6
7	V	20	Licenses and Fees		Evergreen Healthcare Realty, LLC		50	50	7
8	V	21	Office Expense		Evergreen Healthcare Realty, LLC		82	82	8
9	V	21	Prepayment Penalty		Evergreen Healthcare Realty, LLC		92,501	92,501	9
10	V	25	Travel Expense		Evergreen Healthcare Realty, LLC		57	57	10
11	V								11
12	V								12
13	V								13
14	Total			$ 905,802			$ 1,490,413	$ * 584,611	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 17,282	Advanced Therapy and Rehab, LLC	100.00%	$ 17,534	$ 252	15
16	V	39	ANCILLARY REHAB	2,602,061	Advanced Therapy and Rehab, LLC	100.00%	2,640,051	37,990	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,619,343			$ 2,657,585	$ * 38,242	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 119,368	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 47,150	$ (72,218)	15
16	V	10	MEDICAL SUPPLIES	6,041	QUALITY CARE MEDICAL SUPPLY	100.00%	716	(5,325)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	1,670	1,670	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 125,409			$ 49,536	$ * (75,873)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 3,375	$ 3,375	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,093	1,093	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	17,234	17,234	17
18	V	10	SAL-NURSING-M. DEAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	25,105	25,105	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,892	5,892	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	13,912	13,912	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	43,291	43,291	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	16,887	16,887	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	37,388	37,388	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	22,072	22,072	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	28,976	28,976	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	36,128	36,128	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,798	6,798	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	21,023	21,023	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12,289	12,289	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	214,213	214,213	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,009	10,009	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,530	2,530	32
33	V	25	OTHER ADMIN. STAFF TRANS.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	56	56	33
34	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,133	4,133	34
35	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	53,046	53,046	35
36	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,459	11,459	36
37	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,076	3,076	37
38	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	28,938	28,938	38
39	Total			$			$ 618,923	$ * 618,923	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,586	$ 1,586	15
16	V	19	CORP ALLOC/MGMT FEE	1,133,174	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	(1,133,174)	16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V	10	NURSE CONSULTANT	783	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(783)	19
20	V	1	DIETICIAN SALARIES	3,180	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,021	(159)	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	407	407	21
22	V	10A	RESPIRATORY THERAPIST	2,310	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(2,310)	22
23	V	43	MARKETING CONSULTANT	450	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(450)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,139,897			$ 5,014	$ * (1,134,883)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Dir of Operations	Mangement	2.90%	See Attached	11.65	17.92%	Alloc Salary	$ 40,131	17-07	1
2	Beth Benoudiz	CFO	Administrative	0.26%	See Attached	10.04	20.08%	Alloc Salary	34,024	17-07	2
3	Fred Benjamin	Owner	Administrative	1.45%	See Attached	8.41	15.29%	Alloc Salary	43,291	17-07	3
4	Denise Norman	Therapy Mgt	Mangement	0.14%	See Attached	14.3	26.00%	Alloc Salary	35,293	39-07	4
5	Melissa Deal	Nurse Consult	Nursing	0.12%	See Attached	8.4	18.67%	Alloc Salary	25,105	10-07	5
6	Charles Ross	Administrative	Administrative	0.06%	See Attached	8.4	18.67%	Alloc Salary	22,072	17-07	6
7	Barbara Larimore	Bookkeeping	Administrative	0.09%	See Attached	11.8	18.73%	Alloc Salary	10,009	21-07	7
8	Steve Van Camp	Administrative	Administrative	0.29%	See Attached	10.3	18.72%	Alloc Salary	28,976	17-07	8
9	Jeff Elowe	Administrative	Administrative	5.30%	See Attached	1.9	3.45%	Alloc Salary	6,798	17-07	9
10	Mike Filippo	Administrative	Administrative	0.29%	See Attached	8.41	18.68%	Alloc Salary	36,128	17-07	10
11											11
12											12
13								TOTAL	$ 281,827		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						17,534	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						2,640,051	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,657,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						47,150	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						716	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						1,670	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 49,536	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	404,328	8	$ 18,054	$	75,585	$ 3,375	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	404,328	8	5,848		75,585	1,093	2
3	10	NURSING	PATIENT DAYS	404,328	8	92,189	90,660	75,585	17,234	3
4	10	SAL-NURSING-M. DEAL	PATIENT DAYS	404,328	8	134,295	134,295	75,585	25,105	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	404,328	8	31,517		75,585	5,892	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	404,328	8	74,422	74,422	75,585	13,912	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	404,328	8	231,575	231,575	75,585	43,291	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	404,328	8	90,333	90,333	75,585	16,887	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	404,328	8	200,000	200,000	75,585	37,388	9
10	17	ADMIN. SAL. - C. ROSS	PATIENT DAYS	404,328	8	118,071	118,071	75,585	22,072	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	404,328	8	155,000	155,000	75,585	28,976	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	404,328	8	193,262	193,262	75,585	36,128	12
13	17	ADMIN. SAL. - J. ELOWE	PATIENT DAYS	404,328	8	36,364	36,364	75,585	6,798	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	404,328	8	112,461		75,585	21,023	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	404,328	8	65,740		75,585	12,289	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	404,328	8	1,145,893	1,000,220	75,585	214,213	16
17	21	SALARIES-ACCTG-B. LARIMO	PATIENT DAYS	404,328	8	53,541	53,541	75,585	10,009	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	404,328	8	13,535		75,585	2,530	18
19	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	404,328	8	300		75,585	56	19
20	26	INSURANCE	PATIENT DAYS	404,328	8	22,107		75,585	4,133	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	404,328	8	283,762		75,585	53,046	21
22	30	DEPRECIATION	PATIENT DAYS	404,328	8	61,299		75,585	11,459	22
23	32	INTEREST	PATIENT DAYS	404,328	8	16,452		75,585	3,076	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	404,328	8	154,799		75,585	28,938	24
25	TOTALS					$ 3,310,819	$ 2,377,744		$ 618,923	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	404,328	8	8,483		75,585	1,586	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	12,688	2	14,784	14,784			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	12,688	2	1,994				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	41,225	8	39,169	39,169	3,180	3,021	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	41,225	8	5,282		3,180	407	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 69,712	$ 53,953		$ 5,014	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle		X	Mortgage		11/30/99	$ 9,500,000	$ 11,336,667			$ 613,778	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,500,000	$ 11,336,667			$ 613,778	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										4,001	10
11	LaSalle Bank		X	Line of Credit	Interest Only	02/25/00	2,500,000		02/25/02		17,344	11
12	DeLange Landen		X	Equipment	$222.00	09/01/01	8,577	6,127	09/01/05		794	12
13	Hill Rom Beds		X	Equipment				18,323			710	13
14	TOTAL Non-Facility Related				$222.00		$ 2,508,577	$ 24,450			$ 22,849	14
15	TOTALS (line 9+line14)						$ 12,008,577	$ 11,361,117			$ 636,627	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Universal Re		X	Equipment			$	$			$ 14,385	1
2	Interest Income-Facility		X								(1,994)	2
3	Interest Income-EHR		X								(11,466)	3
4	Allocation Boulevard HC	X									3,076	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,001	21

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 937,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (937,500)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 1,417,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 480,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

Property purchased from not for profit. Tax bill not yet received.
Accrual based on real estate tax estimate.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044560

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044560

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,212 B. General Construction Type: Exterior Brick Frame Basement Foundation Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 1,627,500	1
2					2
3	TOTALS			$ 1,627,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		7,977,796	205,597		238,287	32,690	707,358	68
69	Financial Statement Depreciation			4,678			(4,678)		69
70	TOTAL (lines 4 thru 69)		$ 7,977,796	$ 210,275		$ 238,287	$ 28,012	$ 707,358	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,977,796	$ 210,275		$ 238,287	$ 28,012	$ 707,358	1
2	SIGNS	1999	3,440		20	172	172	344	2
3	SEWAGE PUMP	2000	5,305		20	265	265	530	3
4	OFFICE CARPETING	2000	1,834		20	92	92	184	4
5	SEWER PUMP	2000	5,305		20	265	265	530	5
6	PLUMBING	2000	837		20	42	42	84	6
7	ROOF REPAIR	2000	590		20	30	30	60	7
8	KITCHEN REPIPE	2000	1,307		20	65	65	130	8
9	ROOF VENTILATOR	2000	575		20	29	29	58	9
10	REPAIR ROOF TOP	2000	1,075		20	54	54	108	10
11	SPRINKLER REPAIR	2000	750		20	38	38	76	11
12	BOILER REPAIR	2000	1,072		20	54	54	108	12
13	CONCRETE WORK	2001	6,000		20	300	300	475	13
14	CARPET	2001	2,100		20	105	105	149	14
15	WATER HEATER	2001	5,456		20	273	273	341	15
16	COMPRESSOR REPAIR	2001	7,229		20	361	361	602	16
17	CONDUITS	2001	3,550		20	178	178	312	17
18	FILTERS	2001	535		20	27	27	47	18
19	VENTILLATION DOMPERS	2001	900		20	45	45	79	19
20	CONCRETE	2001	2,200		20	110	110	193	20
21	FREEZER PIPING	2001	2,460		20	123	123	226	21
22	FILTERS	2001	545		20	27	27	43	22
23	FILTERS	2001	840		20	42	42	63	23
24	REFRIGERATION REPAIR	2001	574		20	29	29	56	24
25	HYDROGUARD	2001	613		20	31	31	36	25
26	HYDRAULIC GAS VALVE	2001	1,050		20	53	53	57	26
27	WALLPAPER	2001	941		20	47	47	82	27
28	CUBICLE CURTAINS	2002	5,670		20	473	473	473	28
29	REPLACEMENT BLINDS	2002	2,593		20	194	194	194	29
30	NURSE CALL/ POCKET PAGE SYSTEM	2002	1,280		20	96	96	96	30
31	TV HOOK UPS	2002	7,500		20	500	500	500	31
32	TRANSMITTER BANDS	2002	587		20	29	29	29	32
33	CABLING FACILITY	2002	15,002		20	1,375	1,375	1,375	33
34	TOTAL (lines 1 thru 33)		$ 8,067,511	$ 210,275		$ 243,811	$ 33,536	$ 714,998	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,067,511	$ 210,275		$ 243,811	$ 33,536	$ 714,998	1
2	REPLACE FREQUENCY DRIVE	2002	2,900		20	218	218	218	2
3	SECURITY SYSTEM ON EXITS	2002	5,261		20	351	351	351	3
4	SECURITY SYSTEM ON EXITS	2002	(2,874)		20	(120)	(120)	(120)	4
5	REPAIR FIRE SPRINKLER	2002	2,390		20	159	159	159	5
6	REPLACE CONDENSER	2002	1,050		20	61	61	61	6
7	CONVERT DUPLEX TO QUADS	2002	28,300		20	1,651	1,651	1,651	7
8	REPLACE DAMPER MOTOR	2002	1,058		20	35	35	35	8
9	WALL & CHIMNEY WORK	2002	4,240		20	141	141	141	9
10	REPLACE DAMPER MOTOR	2002	1,013		20	25	25	25	10
11	HEAT EXCHANGER	2002	797		20	13	13	13	11
12	HEAT EXCHANGER	2002	525		20	9	9	9	12
13	HEAT EXCHANGER	2002	104		20	2	2	2	13
14	HEAT EXCHANGER	2002	393		20	3	3	3	14
15	HEAT EXCHANGER	2002	3,475		20	29	29	29	15
16	HEAT EXCHANGER	2002	1,775		20	15	15	15	16
17	HEAT EXCHANGER	2002	600		20	5	5	5	17
18	REPLACE COMPRESSORS	2002	4,330		20	253	253	253	18
19	LOCKS	2002	513		20	26	26	26	19
20	EXHAUST FAN	2002	564		20	28	28	28	20
21	AIR TEMP SENSOR	2002	1,002		20	50	50	50	21
22	COUNTER TOP	2002	575		20	29	29	29	22
23	PAINT & WALLPAPER	2002	550		20	28	28	28	23
24	A/C REPAIRS	2002	880		20	44	44	44	24
25	BLACK BOX	2002	635		20	32	32	32	25
26	VENT REPAIR	2002	1,450		20	73	73	73	26
27	CORD FOR SECURITY TV	2002	597		20	30	30	30	27
28	MINI-BLINDS	2002	543		20	54	54	54	28
29	FLOOR PATCH	2002	500		20	25	25	25	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,130,657	$ 210,275		$ 247,080	$ 36,805	$ 718,267	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	242		1999		$ 7,052,500	$ 180,833	35	$ 201,500	$ 20,667	$ 621,292	4
5			1999		303,742	7,788	35	8,678	890	26,757	5
6			2000		103,836	2,662	35	2,967	305	8,901	6
7											7
8											8
	Improvement Type**										
9	DUCT WORK			2000	90,000	2,308	20	4,500	2,192	9,375	9
10	MASONRY RESTORATER			2000	131,234	3,365	20	6,562	3,197	14,218	10
11	PERMIT FEES			2000	5,165	132	20	258	126	559	11
12	PARKING LOT			2000	108,000	2,769	20	5,400	(2,631)	11,700	12
13	PARKING LOT - ENGIN			2000	2,500	64	20	125	61	281	13
14	ARCHITECT FEES			2000	11,619	298	20	581	283	1,356	14
15	SURVEY FEES			2000	2,000	51	20	100	49	217	15
16	GENERAL CONTRACT FEES			2000	25,356	650	20	1,266	616	2,640	16
17	GENERAL CONTRACT FEES			2001	3,538	4	20	15	11	30	17
18	ARCHITECT FEES			2001	3,097	56	20	116	60	232	18
19	LANDSCAPING			2001	27,435	498	20	1,029	531	2,058	19
20	PARKING LOT			2001	50,000	801	20	1,667	866	3,334	20
21	CURB REPLACEMENT			2001	2,200	40	20	83	43	166	21
22	ROOF REPAIR			2001	2,200	35	20	73	38	146	22
23	BATHROOM			2001	2,250	36	20	75	39	150	23
24	TILE WORK			2001	500	7	20	15	8	30	24
25	KITCHEN WORK			2001	3,900	54	20	114	60	228	25
26	VENDING AREA WORK			2001	1,900	27	20	55	28	110	26
27	KITCHEN WORK			2001	1,084	15	20	32	17	64	27
28	A/C UNITS			2001	4,884	68	20	142	74	284	28
29	SHEET METAL SYSTEM			2001	9,540	112	20	239	127	478	29
30	ARCHITECT FEES			2001	4,579	24	20	57	33	114	30
31	BUILDING IMPROVEMENTS			2002	6,480	586	20	324	(262)	324	31
32											32
33	Allocated Boulevard Healthcare			2002	18,257	2,314	20	2,314		2,314	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,977,796	$ 205,597		$ 238,287	$ 27,428	$ 707,358	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,402,565	$ 513,394	$ 242,333	$ (271,061)	10	$ 720,987	71
72	Current Year Purchases	238,292	9,295	16,798	7,503	10	16,798	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,640,857	$ 522,689	$ 259,131	$ (263,558)		$ 737,785	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,399,014	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 732,964	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 506,211	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (226,753)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,456,052	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Alloc. Boulevard HC				28,938			6
7	TOTAL				$ 28,938 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 32,100 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 221,098	$		$ 221,098	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			63,450			63,450	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			2,338,969			2,338,969	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				795,847		795,847	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						651,872		651,872	13
14	TOTAL			$		$ 2,623,517	$ 1,447,719		$ 4,071,236	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,483	$ 593,521	1
2	Cash-Patient Deposits	29,509	29,509	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,418,775	3,418,775	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		1,259,529	5
6	Prepaid Insurance	157,119	157,119	6
7	Other Prepaid Expenses	6,307	6,307	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	1,063,299	62,455	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,685,492	$ 5,527,215	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,627,500	13
14	Buildings, at Historical Cost		7,052,500	14
15	Leasehold Improvements, at Historical Cost	76,338	575,798	15
16	Equipment, at Historical Cost	438,325	2,597,528	16
17	Accumulated Depreciation (book methods)	(118,194)	(2,599,665)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		542,860	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 396,469	$ 9,796,521	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,081,961	$ 15,323,736	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,331,250	$ 1,331,250	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,509	29,509	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	203,975	203,975	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,263	15,263	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,417,500	1,417,500	32
33	Accrued Interest Payable		70,090	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	14,698	14,698	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,012,195	$ 3,082,285	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,450	24,450	39
40	Mortgage Payable		11,336,667	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 24,450	$ 11,361,117	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,036,645	$ 14,443,402	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,045,316	$ 880,334	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,081,961	$ 15,323,736	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 644,744	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 644,744	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,400,572	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,400,572	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,045,316	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,839,626	1
2	Discounts and Allowances for all Levels	(8,478,043)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,361,583	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,429,153	6
7	Oxygen	133,143	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,562,296	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,834	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,676,141	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	243,177	19
20	Radiology and X-Ray	90,000	20
21	Other Medical Services	420,219	21
22	Laundry	1,908	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,462,279	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,994	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,994	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,277	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,277	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,389,429	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,792,459	31
32	Health Care	6,528,475	32
33	General Administration	3,914,776	33
	B. Capital Expense		
34	Ownership	1,451,923	34
	C. Ancillary Expense		
35	Special Cost Centers	4,168,729	35
36	Provider Participation Fee	132,495	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,988,857	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,400,572	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,400,572	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,677	1,871	$ 64,044	$ 34.23	1
2	Assistant Director of Nursing	1,315	1,398	35,225	25.20	2
3	Registered Nurses	81,221	90,477	2,058,767	22.75	3
4	Licensed Practical Nurses	65,001	76,746	1,432,850	18.67	4
5	Nurse Aides & Orderlies	164,034	201,885	1,887,321	9.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,013	12,677	156,314	12.33	8
9	Activity Director	1,874	2,326	29,306	12.60	9
10	Activity Assistants	8,736	9,906	94,508	9.54	10
11	Social Service Workers	8,185	9,162	129,698	14.16	11
12	Dietician	1,529	3,156	47,660	15.10	12
13	Food Service Supervisor	2,058	2,301	34,775	15.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,634	41,319	293,033	7.09	15
16	Dishwashers					16
17	Maintenance Workers	6,758	8,076	118,873	14.72	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,847	2,229	98,767	44.31	20
21	Assistant Administrator	1,814	1,977	48,964	24.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,391	39,780	394,899	9.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,646	1,881	25,548	13.58	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,385	6,238	100,361	16.09	33
34	TOTAL (lines 1 - 33)	428,118	513,405	$ 7,050,913 *	$ 13.73	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	280	$ 7,553	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	Monthly	19,200	10-03	38
39	Pharmacist Consultant	Monthly	13,524	10-03	39
40	Physical Therapy Consultant	178	8,012	10a-03	40
41	Occupational Therapy Consultant	143	6,435	10a-03	41
42	Respiratory Therapy Consultant	50	2,310	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,656	11-03	44
45	Social Service Consultant	17	875	12-03	45
46	Other(specify)				46
47	Alzheimers Consultant	Monthly	1,458	10-03	47
48	Wound Care Consultant	313	50,350	10-03	48
49	TOTAL (lines 35 - 48)	1,113	$ 157,501		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Greg Kennedy	Administrator	.58%	$ 98,767
Mike Stoudt	Asst. Admin.	0	48,964
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 147,731

B. Administrative - Other

Description	Amount
Managment Fees - Boulevard Healthcare Mgmt	$ 1,133,174
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,133,174

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	$ 43,890
Gardner Carton & Douglas	Legal	11,148
Seyfarth Shaw	Legal	2,242
Bianculli & Impink	Legal	6,134
Morgan Lewis & Bokius	Legal	12,935
Frost Ruttenberg & Rothblatt	Accounting	38,592
See Attached	Computer Expense	13,684
Hansen Associates	Architects(Related to JCAHO)	2,207
Personnel Planners	Unemployment Tax Cons	2,205
See Attached	Various	12,638
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 145,674

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,871
Unemployment Compensation Insurance	84,411
FICA Taxes	520,042
Employee Health Insurance	297,425
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	15,986
Employee Benefits	33,399
Life Insurance	10,481
Disability Insurance	39,028
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,120,643

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24,317
Health Care Worker Background Check	6,528
(Indicate # of checks performed 466)	
Advertising & Promotion	51,034
Dues & Subscriptions	9,465
Licenses, Permits& Fees	10,138
Allocation Blvd.	12,290
Less: Public Relations Expense	( )
Non-allowable advertising	(51,034)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,738

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,806
Allocation Blvd.	2,530
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,336

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EVERGREEN HEALTH CARE CENTER # 0044560 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council $13,673**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **122** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **132,495**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees